

Case Number:	CM13-0072366		
Date Assigned:	01/08/2014	Date of Injury:	09/27/2009
Decision Date:	06/02/2014	UR Denial Date:	11/22/2013
Priority:	Standard	Application Received:	12/26/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Family Medicine and is licensed to practice in Arizona. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient has a date of injury of September 27, 2009. Diagnoses include myalgia/myositis, reflex sympathetic dystrophy, sprain of neck, sprain of shoulder, and recurrent depression. Subjective complaints are of low back pain, neck discomfort with radiation, and head heaviness. Physical exam shows antalgic gait, tenderness to palpation of the spinous processes, and decreased muscle strength in the upper and lower extremities. Prior cervical CT scan reveals degenerative disc disease. Prior lumbar CT scan shows 3mm disc protrusion at L4-L5 and 2mm bulge at L3-L4. Prior treatments have included permanent spinal cord stimulator placement on December 10, 2011, functional restoration program, and physical therapy. Recent physical therapy was in December 2013 for 12 visits, which were reported as helpful. Medications include butrans, omeprazole, Norco, Lunesta, Xanax, and sertraline.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

OUTPATIENT [REDACTED] HELP PROGRAM, X 3 WEEKS: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Programs Page(s): 31-34.

Decision rationale: The California MTUS identifies specific criteria for inclusive in a functional restoration program including; adequate and through prior investigation, failure of previous treatment modalities, significant loss to function independently, not a surgical candidate, and patient exhibits motivation to change. Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. The patient has previously completed a functional restoration program, and it was documented as being beneficial. Submitted documentation shows evidence that the patient meets California MTUS criteria. Therefore, the request for the ████████ HELP program is medically necessary.

BUTRANS 10 MCG/HOUR #4: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Buprenorphine Page(s): 74-96,26. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

Decision rationale: The California MTUS and the Official Disability Guidelines recommend buprenorphine for treatment of opiate addiction. Buprenorphine is also recommended as an option for chronic pain. Buprenorphine's usefulness stems from its unique pharmacological and safety profile, which encourages treatment adherence and reduces the possibilities for both abuse and overdose. Studies have shown that buprenorphine is more effective than placebo and is equally as effective as moderate doses of methadone in opioid maintenance therapy. The patient in question has been on chronic opioid therapy with buprenorphine. The Chronic Pain Medical Treatment Guidelines have specific recommendations for the ongoing management of opioid therapy. Clear evidence should be presented indicating the degree of analgesia, level of activity of daily living, adverse side effects, or aberrant drug taking behavior. For this patient, clear documentation shows stability on medication, increased functional ability, and no adverse side effects. Furthermore, documentation is presence of MTUS opioid compliance guidelines, including urine drug screening, risk assessment, and ongoing efficacy of medication. Therefore, the use of this medication is consistent with guidelines and is medically necessary for this patient.

XANAX 1MG, #80: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: The California MTUS guidelines do not recommend anxiolytics as first line therapy for stress-related conditions as they can lead to dependence and do not alter stressors or the individual's coping mechanisms. Benzodiazepines, in particular, are not recommended for long-term use because long-term efficacy is unproven. Most guidelines limit use to 4 weeks, due

to dependence and tolerance that can occur within weeks. For this patient there is no documentation indicating rationale for medication and does not identify subjective or objective signs consistent for benzodiazepine therapy. Therefore, the medical necessity of Xanax is not established.

OMEPRAZOLE 20MG, #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs/GI Risk Page(s): 68-69.

Decision rationale: According to the California MTUS guidelines, a proton pump inhibitor can be added to NSAID therapy if the patient is at an intermediate to high risk for adverse GI events. Guidelines identify the following as risk factors for GI events: age >65, history of peptic ulcer, GI bleeding or perforation, use of ASA, corticosteroids, anticoagulant use, or high dose NSAIDS. There is no documentation identified that would stratify this patient in an intermediate or high-risk GI category. Furthermore, there is no documentation that demonstrates ongoing GI complaints. Therefore, the medical necessity of omeprazole is not established.

LUNESTA 3MG, #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Insomnia Treatment.

Decision rationale: The Official Disability Guidelines state that pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbances to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. For this patient, submitted documentation did not show evidence of evaluation for insomnia, or documentation of duration or ongoing efficacy of this medication. Therefore, the medical necessity of Lunesta is not established.